Client Name: _____ Client #:_____ Adm. Date: _____

Kevin Makarewicz LPC
31 Halsey Dr. Old Greenwich, CT 06870
203-698-2465 www.KevinMakarewicz.com

CONSENT TO TREATMENT

I understand that there can be benefits to our working together such as improved communication, interpersonal relationships, or methods of coping. While I expect benefits from this treatment, I fully understand that because of factors beyond our control or other factors, such benefits and particular outcomes cannot be guaranteed. I may experience emotional strains, feel worse during treatment, and make life changes that may be distressing.

I understand that this therapist is not providing an emergency service. I may leave a voice mail message at **203 698 2465**. If this is an emergency and I am unable to wait for a return call, I will call **911**.

I understand that conversations with the therapist and my records are confidential except in the following situations:

1. I am in serious danger of harming myself or at serious risk for harming another person (when under 18, chronic or increased substance abuse or acting out behavior may constitute form of danger to self or other and parents may be informed).
2. I am abusing or neglecting a child, an elderly person, or a disabled person in my care or I am the recipient of that abuse or neglect.
3. A court order compelling my therapist to release records.
4. In certain supervisory or peer review situations and then my identity is concealed whenever possible.
5. In the case of a minor, **both parents are entitled to medical records**.

I understand that I am financially responsible for all sessions and payment is due at the time service is rendered unless other arrangements have been made in advance. Fees for a 55 minute session are $180.00; group sessions are $65 per person.

I will attend all agreed upon sessions and if unable to keep an appointment will notify the therapist at least 24 hours in advance. **Failure to give 24 hours notice will result in a full session fee of $180.00.** Continual issues with not showing up at the time of appointment can result in discharge.

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I understand that insurance will not reimburse me for missed sessions, nor will they pay for the following services: Phone calls/phone sessions, letters/reports, disability paperwork or consultations. Services that are requested but not covered by insurance will be billed directly to me at a rate of $180.00 per hour. These include but are not limited to: Phone based work that lasts over 5 minutes, letters/reports (non routine), or court related matters.

I am free to discontinue treatment at any time; however, I realize that when I have reached my goals it is important for me to discuss this in session and plan for termination with my therapist. If I do plan to discontinue treatment, I will advise my therapist.

I know of no reason I should not undertake this therapy. I have read this policy, have been given a copy of it. I am in agreement with the above conditions.

I,_____, give my permission and consent to Kevin Makarewicz LPC to provide psychotherapeutic treatment to me and the following family members (if applicable):_____
_____
_____

_____ _____
Client Date

_____ _____
Parent/Guardian or legal representative (as applicable) Date